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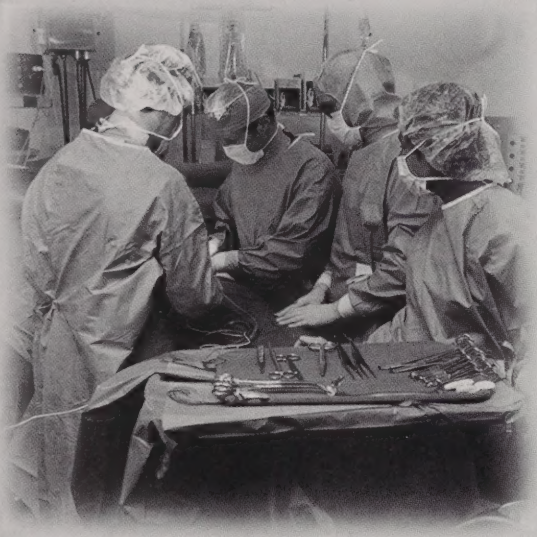

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THE
Hampden Hippocrat
Winter 1997

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On our cover is "Autumn in Vermont", a photo by Dr. Norman Halpern.

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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HAMPDEN DISTRICT MEDICAL SOCIETY 1997-1998 SEASON

DISTRICT MEETING

PLACE: **SHERATON SPRINGFIELD**
Monarch Place Hotel
One Monarch Place, Springfield, MA

DATE: Tuesday, January 27, 1998

BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 6:30 p.m.

DINNER: 7:00 p.m. SPOUSES ARE WELCOME!

SPEAKER: Nancy W. Dickey, M.D.
President-Elect, American Medical Association

NOTE: If you must cancel your dinner reservation, please call the HDMS office before noon on January 27th. If the cancellation is not made, you will be BILLED for your dinner.

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I shall bring my spouse _____

I shall bring a guest (name) _____

CHOICE OF MEAL: *(please check one)*

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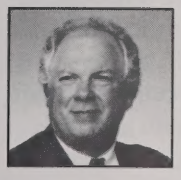

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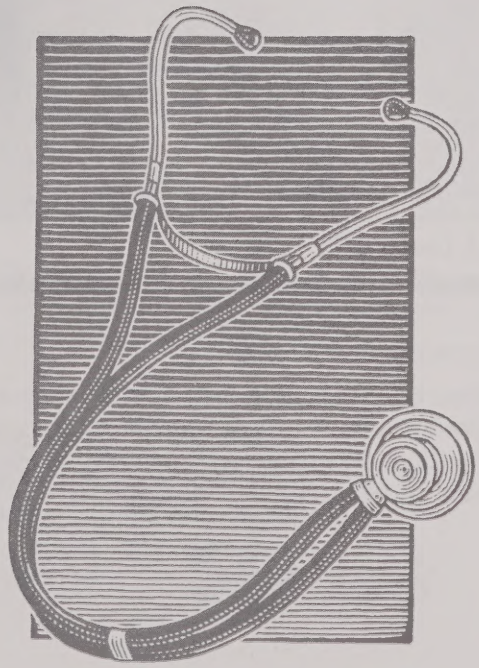
From The Editor

David Letterman's list of 10 things that won't happen in the Pioneer Valley health care system in 1998 would surely include: 1) the sale of the only physician founded and owned HMO locally to the largest area hospital who now contemplates its sale to an organization ten times as large. 2) the sale of the largest, oldest staff model HMO in the area to a for profit national corporation of physician practices. Dave knows those things won't happen in 1998 because they've already happened in 1997.

This issue of the Hippocrat with its coverage of A Call to Action explores physician response to the evolution of market place medicine. An article covering the medical religious seminar looks instead at new approaches to healing. Dr. Samuel Potsubay offers his own whimsical perspective on the "length of stay." Dr. Norman Halpern, who has been recognized nationally for his photography, has generously agreed to supply us with his work for use on the front cover. This photo "Autumn in Vermont" is his first. Dr. James Wang continues to photograph participants in the society's activities. Best Wishes for another compelling and rewarding year in practice. ■

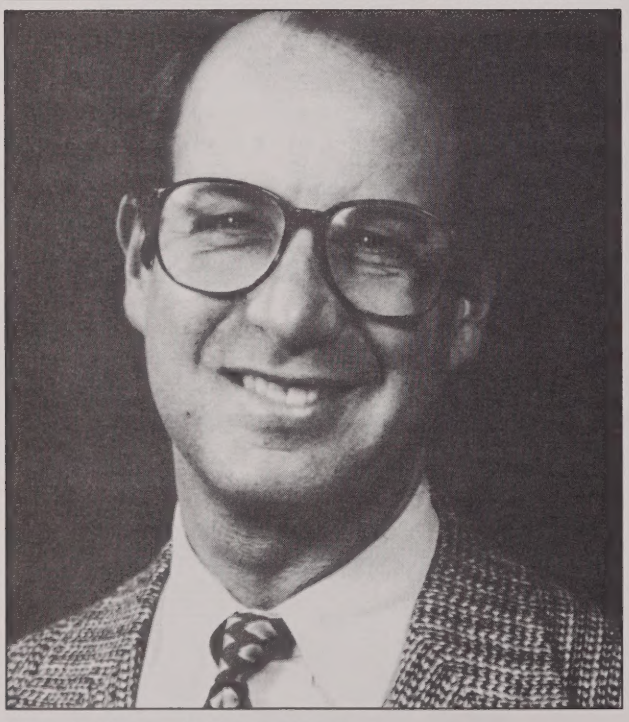
Brigid Glackin, M.D.
Editor



"Miami Medicine"

Once I had a practice in Miami.

It began after residency and ended eighteen months later after a friend was arrested for attempted murder of his former medical partner and I saw him on the front page of the Miami Herald in handcuffs. I returned to New England to then work in a sane place.



Marc A. Linson, M.D., President

Miami in 1980 was on fire. In every way: excessive entrepreneurism, decadent lifestyles and Liberty City riots characterized the wild west of America and of American Medicine. It took years before the rest of the country caught up to us, if it ever did.

I was in a three person practice. There was a fourth doctor, who as a result of a tiny cut on his right fifth finger was collecting total disability as a surgeon and working part-time in the office. His infirmity did not affect his shifting hand and the sports car was replaced with a Rolls Royce, which enhanced his local reputation nearly as much as his legendary "big score".

This had been selling a share of a small hospital he owned to Humana Corporation for one thousand percent profit two years before I arrived in Miami, which, I learned, everyone now aspired to repeat.

Medicine was a business in Miami. Not a profession, not a special calling, not a trusted relationship with the patients. It was, simply, a way to make tons of money, any way you could. Insurance fraud,double billing, exorbitant fees, associations with ambulance-chasing attorneys, unnecessary surgery, exaggerated treatments, ownership of physical therapy, and even hospitals was standard practice. Anything went. There were no limits on what activity was permissible, no ethical boundaries, until you were caught. And few were.

Patients were treated as commodities; You aggressively and intentionally were suppose to exploit them and their health insurance to use their illness as an excuse to provide all services imaginable until their financial resources were exhausted, and then, to pass them on to a colleague, a referral, for your friend to do the same, and thereafter send one back to you.

And one day as you accumulated riches you could maybe own a share of a hospital and over

utilize it as well, until it was sold, or sit back in your office waiting for the wealthy South Americans and drug dealers to come in for treatment with a suitcase of cash for pre-payment. I remember thinking it would take the wrath of God or the Government to set it all straight.

So how could my friend, in this city, to all appearances an excellent cardiologist, resist the offer made by a mutual patient, a retired Don, to "rub out" an annoying ex-medical partner who was giving him difficulties over splitting their pension fund. The unfortunate discovery of this conspiracy, well on its way to completion by then, by a coincidental FBI wire-tap sting operation, led to his high profile public arrest.

I shortly thereafter finalized my plans to return to a safer place for the good practice of medicine. ■

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Ad Hoc Committee for the Defence of HealthCare

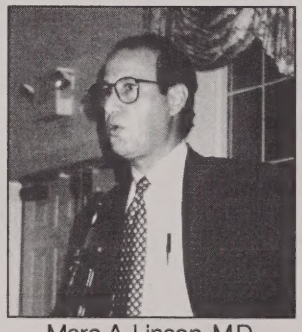
A Call to Action - the HDMS Fall Meeting

Brigid K. Glackin, M.D.

The fall meeting of the Hampden District Medical Society was held at the Delaney House in Holyoke on September 23, 1997. District President Dr. Marc Linson provided an introduction to the evening's topic: a discussion of grass roots efforts by Massachusett's physicians to take action against the impact of managed care on the practice of medicine.

Dr. Linson's remarks are summarized below.

"The crisis in health care caused by the corporization of American medicine has been with us for sometime now. Almost all of our authority as physicians has been lost. There has been an intrusion of profiteers into our hospitals, offices, and lives that is tearing apart our relationships with each other and with our patients as well. Some are seeking security by selling our practices to managed care companies; others are depending on insurers, but risk resenting their sickly, costly patients. Is there a safe haven from this. -from the guardians of the insurance companies' ledgers who tell us what to do but absolve themselves of liability, while lowering costs by reducing care? Can we deal with this monster in our midst-the profit-driven corporate takeover of medicine? We have been demeaned from our status as doctors to providers. At the same time, as care is being rationed, the treasure of the infrastructure of American medicine is being dismantled for the benefit of Wall Street stockholders."

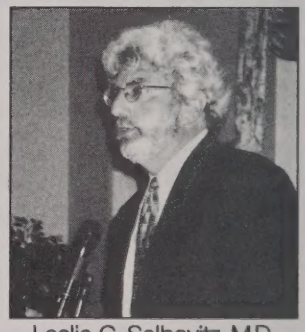


Marc A. Linson, M.D.

Our speaker tonight will address these issues and guide us toward what has been described by some as the second Boston tea party. I have asked Dr. Leslie Selbovitz, Medical Director of clinical practices, quality assurance and utilization management at Baystate Medical Center to present our guest speaker from the Ad Hoc Committee for the Defense of Medicine.

Dr. Selbovitz:

I think Marc asked me to introduce our speaker because since the early 1980s, I have been involved with a variety of organizations taking a look at how one balances the issue of quality in health care with the use of health care resources. I have seen enormous changes from the worse in the last few years. Utilization reviewers who a few years ago were questioning, perhaps appropriately, whether people needed to be in the hospital for being emotionally tired without acuity to their illness, are now authorizing care for one day only for patients admitted to Baystate to the ICU from the Emergency department with multi system failure. When we attempt to justify continuing care for the person in the ICU to the people who are pulling the pursestrings this is part of the dumbing down of decision making healthcare. I feel demeaned as an MGH trained doctor trying to explain the complexities of ICU care to a nurse who can't pronounce the language in a way that would make me feel there's any hope for a meaningful dialog. There's also a dumbing down in the way that we globally evaluate how doctors take care of populations of patients. There's still a vast gap between guidelines and cost effective



Leslie G. Selbovitz, M.D.

All photos by Dr. James Wang

methodologies that are based on large populations and what doctors do when they care for patients one by one. Sometimes patients need additional days in the hospital for a lot of complex psychosocial reasons and from what I see there's not a dollar for compassion. I think once we begin to let this process erode the doctor-patient relationship we are complicit in the failure to provide compassionate care. A few quick fixes are needed. I want senior managed care executives to be judged by health care outcomes, more so than being judged by how much profitability they have produced by limiting services to patients. I'd also like to see more involvement by HMOs in graduate medical education.

I also want to see a way that some legitimate science is brought to physician and hospital profiling. The current data is gobbletigook which can't sustain any scientific challenge. With that as an introduction. I take pleasure in introducing Dr. Susan Bennett, Dr. Bennett is a graduate of the University of California at San Francisco. She did a primary care internal medicine residency at Cambridge Hospital. She has had a wide range of publications including basic science but also looking at the delivery of health care services, particularly services to women. She has been nominated for a distinguished teaching award at the Beth Israel and has been involved with hospitals in the Harvard system. She is an associate in the Lown Cardiovascular Group in Brookline, Massachusetts.

Dr. Bennett:

I would like to tell you how the Ad Hoc Committee for the Defense of Health Care began. In the winter of 1996, after David Himmelstein and Steffie Woolhandler published in the New England Journal a scathing paper detailing the excesses of U.S. health care, I approached Dr. Himmelstein to meet with Dr. Lown regarding organizing physicians to begin a dialog among ourselves about what we could do. Dr. Lown had began a physician movement in the 1940s, the Physicians for Social Responsibility. It was many years before this group was able to make inroads in the medical establishment and ultimately receive the Nobel Peace Prize in 1987 for the group's work in the area of nuclear disarmament. In my political naivete at the time, I was hoping that we might be able to merge Physicians for Social Responsibility with Physicians for National Health Insurance. I perceived at the time an extraordinary threat to my ability to practice medicine. Dr. Lown said "Absolutely not. If you think the military industrial complex was difficult to take on, just try to take on the medical industrial complex." Dr. Lown did agree to meet with us to discuss some strategies we might employ and in February, 1996, we wrote a first draft of "A Call to Action." A year later, we wrote a new draft with a group that included the head of the Massachusetts Nurses Association, Duressa McCabe and Suzanne Gordan, the journalist who coined the term "drive-by delivery." We now have over 3000 endorsements and have an executive director and we hope you will join us.

Susan E. Bennett, M.D.

So-what are we about? The first issue we wanted to address is that there must be an uncoupling between money making and the care of patients. This is an issue we have been struggling with for 3000 years. The care of the sick and the dying has always been lucrative. There has always been a tremendous opportunity to make money from other people's suffering. The AMA's Principles of Medical Ethics in 1957, stated, "A doctor must not dispose of his services to patients under terms or conditions that interfere with the exercise of his medical judgment and skills." We believe that doctoring has to be a scientific endeavor and a humane calling. The dissociation between profiteering and clinical judgment was really the basis of the respect afforded doctors in the 1940s and 1950s. It's extraordinary that profiteering is no longer viewed as corruption of the doctor-patient relationship. In fact market medicine is now considered the standard-it's socially responsible with effective resource allocation.

The doctor-patient relationship is based on the premise that patient needs take precedence over other considerations. When I was working as a house officer this became apparent to me-I couldn't sleep, sometimes I couldn't eat. This experience-which I didn't enjoy very much of-transformed and professionalized me. The way it did that was by convincing me that a sick patient's needs came before mine.

What about applying the industrial model to health care? In this model, the customer is the

Continued on next page

A Call to Action
Continued from previous page

patient. The provider or doctor is skilled labor. I don't want interchangeable skilled labor taking care of my child when she is sick and I don't want to be skilled labor. This is because this is not what I trained to do. I have a professional identity. With de-professionalization, we will lose the trust of our patients. Without trust, there will be no healing and without healing we are completely interchangeable. I have become a care gatekeeper - this is a phenomenally slippery slope. Dr. Lee of the Mayo Clinic commented, "The gatekeeper serves the interests of the owner of the gate, not of the people who are trying to get through". This Faustian deal for primary care physicians was one in which many of us had no choice. In April, 92 of my patients received a letter on Friday afternoon saying I was no longer their doctor, with a card saying emergency services will be covered until you choose a new provider. My phones were ringing off the hook. In particular, a young woman I diagnosed with a brain tumor that week had seen a surgeon at the Mass General and had her MRI scan there and her surgery had been scheduled. This family was just beginning to cope, received a letter saying that they could switch to the Brigham and Women's Hospital where I would be their doctor or choose a new primary care doctor at the Mass General. This was because some bureaucrat had decided that because there are two separate IPAs even though I have dual admitting privileges and the two hospitals are now the same corporate entity, I could not belong to both IPAs. So without informing me or giving me notice (to this day no one taking responsibility for this) 92 of my patients received a letter saying I could no longer be their doctor. I was interchangeable in the eyes of this bureaucratic structure ultimately. I betrayed my patients through no fault of my own.

I would like to share with you the facts -in case you find this all too emotional-and give you a fast slide show of the data. A 59 year old man is involved in a motor vehicle accident and is taken to an emergency room where there is literally bone and brain protruding from his head. He has a "negative wallet biopsy". No insurance card found. He is transferred to a city hospital where a C-l fracture is diagnosed. Four days later, the hospital finds that he is in fact one of their patients and asks that he be transferred back to their hospital. The number of uninsured Americans has grown to 41 million. Senior citizens are now paying 21% of their income toward their health care. All of us are under insured when it comes to long term care as Christopher Reeves found out after his equestrian accident. Poor access to health care in this country is responsible for I think the disgraceful shorter life expectancy for men in comparison to other industrial economically advanced countries. This poor access-exists despite the current 200 thousand empty "surplus" medical beds nationally. A glut of physicians has been proclaimed and some medical schools are being paid to train less people. Nurses are being laid off. There's no dearth of jobs for health care administrators who are currently gobbling up twenty five percent of the health care dollar in America.

Health care administration guidelines tell us that we cannot have cataracts removed in more than one eye unless we're young and need our eyes to work. We cannot stay overnight after vaginal deliveries or mastectomies. Milliman and Robertson is the health care consulting company that has written these and other guidelines for the health care of more than 50 million Americans.

Our group has no problem with managed care as a concept in the abstract. It's the manipulation of managed care as a mechanism for Wall Street to take over American health care. We keep putting patients into larger and larger organizations when they tell us over and over that they prefer the small office setting.

In a study carried out by Rand in a prospective randomized manner, poor, high risk patients had worse outcomes in a prepaid health plan than in a fee for service setting,(JAMA, 1996). The irony of this is that Medicare HMOs don't save money.

Some people have done quite well with managed care. Len Abramson, the CEO of U.S. Healthcare, made only $4 million in 1994, but he made $990 million in 1995. A very high proportion of US Healthcare premium dollar goes for overhead and profit with a low medical loss ratio. A significantly lower proportion goes to actual patient care relative to other plans. There's retribution with for profit HMOs. Aetna Health Care named one physician its primary care doctor of the month and then fired him for exceeding their cost per patient guidelines. This is actually a diagram from an HMO manual. It says "Clinical renown is a cost magnet." The University of California at Irvine's hospital chief wrote in a let-

ter to the faculty. "We can no longer tolerate patients with expensive and complex conditions being encouraged to transfer to our facility." National Medical Enterprises is a notorious company that practiced picking healthy young people off the street and hospitalizing them in psychiatric hospitals owned by them until the day their insurance ran out. This same company has reorganized as a company called Tenant which is the second largest for profit hospital chain in America, despite the fact that they had to pay $379 million in fines for their previous fraudulent practices.

As the Ad Hoc Committee for the Defense of Health Care, we do not assert that we have the solution to these problems, but we are driving 1000 miles per hour down a deadend street and we hope to stop immediately. We call for an immediate moratorium on all for profit takeovers of medical practices, hospitals and health plans. It's not that we think the not for profits are so terrific. The immediate threat is the take over of the doctor-patient relationship by market medicine. We also feel that there needs to be a national debate and that the American public needs to be informed about what's going on at the grassroots level. We cannot accommodate with so called managed care. We must remain on the moral high ground for the sake of our patients.

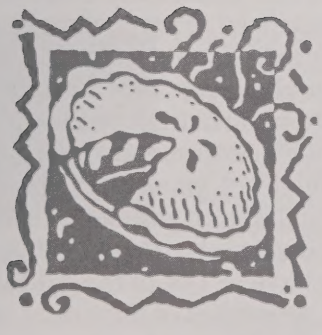
Dr. Linson then invited Dr. Bennett and Dr. Jeffrey Scavron to field questions regarding the Ad Hoc Committee and A Call to Action.

Dr. Scavron suggested that physicians should step up and take responsibility for a lot of what's been going on. He pointed out that organized medicine in the past had fought against Medicare and Medicaid and health care reform. He expressed the belief that in the past the AMA has functioned as a trade organization to protect doctors' interests and has not aligned itself with the interests of the people of this country.

Dr. Koppelman expressed the belief that organized medicine was fighting for the same agenda through legislation sponsored by the Mass Medical Society.

Dr. Bennett suggested that we should tell our patients honestly why their choices of specialty physicians are restricted in capitated health plans to physicians within the network instead of giving them some bogus explanation about continuity of care or access to reports.

Dr. Bennett concluded by noting a planned Boston Tea Party for December 2, the day before the Call to Action petition appears in the JAMA. Fanieull Hall has been rented and using the Boston Tea Party boat a week's worth of paperwork in an ecologically safe way will be dumped into the harbor. Following this demonstration, a more solemn meeting will be held with hook up by satellite to 21 other states to kick off the national debate. ■



Spirituality and Healing - The Forgotten Factor in Physical and Mental Health: What Does The Research Show?

Brigid K. Glackin, M.D.

The thirteenth annual Medical Ethics seminar was held at the Deliso Center at Mercy Hospital, October 8, 1997. Sr. Margaret McCarthy, Co-Chair of the H.D.M.S. Medico-Religious Committee with Dr. Roland Stebbins, welcomed the attendees. Reverend Bruce K. Benander introduced Dr. David B. Larson, M.D., M.S.P.H., from the National Institute for Healthcare Research in Rockville, Maryland.

Dr. Larson quoted Sir William Osler as saying that faith is wonderful, but immeasurable, implying that it cannot be researched or studied. Dr. Larson recounted that he began his career at the NIH as a research psychiatrist. Dr. Larson quoted the National Academy of Sciences opinion dogmatically that the discussion of "religion and science are mutually exclusive." This statement in 1984 was made in response to creationism, but was seen by Dr. Larson as an overstatement without supporting data. Dr. Larson says that there has been a huge change in the last few years and now 25% of medical schools have courses in religion, spirituality and health, not just in medical ethics.

Regarding U.S. religious beliefs and attitudes, 88% of the U.S. population believes in the power of prayer according to Gallop Studies. 77% believe that God can intervene to cure those with a serious illness. 63% believe that doctors should talk to patients about their spiritual faith according to U.S. News and World Reports. 64% believe doctors should pray with their patients if asked. Only 48% of psychiatric patients see themselves as deeply religious, but up to 77% of medical surgical patients see religion as an important source of support and comfort. In surveys of patient needs for spiritual or religious support at times of terminal illness, 90% of regular attendees of churches or synagogues feel that doctors should refer them to chaplains or spiritual advisers in times of serious illness.

"Dr. Larson suggested that religion is a forgotten factor in medical studies and one that can be systematically approached."

Dr. Larson suggested that religion is a forgotten factor in medical studies and one that can be systematically approached. He reviews studies in various specialties in medicine and found only 3% of psychiatric studies included religion as a factor, despite their effort to look at all significant psychosocial factors. 80% of studies that looked at religion had no research citations.

Of studies examining the relationship of religion and mental health, 83% found a positive relationship. This is despite the attitude in various theories of emotional health that religiosity is associated with emotional disorder. Dr. Larson says that it can be shown empirically to be beneficial in preventing illness, promoting recovery from illness and surgery, and assisting in coping with illness. Dr. Larson gave examples of data showing that adolescent suicide risk is less in those with religious affiliation. He also quoted a study of the development of alcoholism in John Hopkins medical school graduates that participation in religion correlated with non-drinking behavior in a school where 13% of the graduates became alcoholics. In studies of illicit drug use, religious participation correlated with young black men who got out of the ghetto without drug problems. Population studies from Alameda County,

California found lower mortality rates over 30 years in church attendees. Adjusting for poor health practices did not change non-attendees mortality rates.

More than 50% of elderly patients cited religion as a significant factor in coping with major illness. Dr. Larson said that he was not saying we should push religion on people, but instead suggesting that where important to people it should be included in their health care. He cited studies of gynecologic cancer, breast cancer and renal dialysis patients where patients felt that their faith was helping them cope, improving their sense of selfworth and aiding in their recovery. 96% of patients used prayer to assist them in coping with cardiac surgery. A study of 232 patients undergoing cardiac surgery at Dartmouth, showed that at 6 months 9% had died. Mortality rates were twice as high in patients who never attended church, after controlling for other factors. A psychiatrist who went with a team of community psychiatrists to assist the families of victims of the U.S. Air crash in Pittsburgh said that 75% of those approached when asked if they needed help from the psychiatrist were asked in return, "Will you pray with me?" Studies of success in psychotherapy show that for religious patients, religion should be included in their therapy. They also show that differences in ethnicity or gender between patient and therapist are less significant in determining outcome than differences in religious perspective; the atheist psychiatrist with the born again Christian patient. The majority of patients need a practitioner who is sensitive and sympathetic to their religious perspective.

Dr. Larson suggested in conclusion that religion and faith are not so mysterious or unmeasurable as Osler wrote and that faith can be measured by its effects. ■

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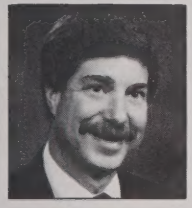

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Arthur W. Price

Arthur W. Price and Michele J. Feinstein, partners in Cohen, Rosenthal have more than twenty-five years of combined experience in representing area physicians in their practices and individually. They counsel solo and group practices in their day to day business as well as in their planning for growth or extraordinary concerns. They also advise physicians on personal and family problems.

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Liability For Cost Containment Decisions And The Impact Of ERISA

Kevin C. Giordano, Esquire

In California, Lois Wickline[1] was admitted to Van Nuys Community Hospital suffering from an occlusion of the abdominal aorta. Following surgery, the patient had a stormy course, experiencing severe pain in her lower leg with episodic spasms. Mrs. Wickline also suffered from hallucinations. The patient was expected to be discharged within 10 days after surgery, however due to these complication, her physician determined that she needed an additional eight days of hospitalization. Her third party payor, insurance carrier Medi-Cal, however, advised that it would only authorize an additional four days of in-patient care.

At the conclusion of the four authorized days and without further discussions with the Third Party payor, Mrs. Wickline's treating physician discharged her from Van Nuys Hospital. Following her discharge, the patient experienced a complete occlusion of the right infra-renalaorta necessitating an amputation of her right leg. She brought suit against the State of California for harm caused by its utilization review mechanism. She also sued her treating physicians complaining they were negligent in allowing their medical judgement to be inappropriately affected by the insurer's cost containment program. In its 1986 decision, the Court determined that although a Third Party payor can be held legally responsible for medically inappropriate decisions that result in adverse medical consequences, in this instance Medi-Cal was not liable since it did not override the medical judgement of Wickline's physicians at the time of her discharge. In its ruling, the Court also stated that a physician "cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour."[2] A subsequent 1990 California decision also concluded that a third party payor can be held responsible if a refusal of benefits was a "substantial factor" in causing injury to a beneficiary. However, it too reiterated the physician's role in exercising professional judgement and the obligation to act as gatekeeper and advocate.[3]

Presently, the effects of Managed Care have increased physician liability risks for medical treatment decisions based upon HMO utilization management, but there has not been a concomitant increase in liability risk for the Managed Care Organizations (MCO's) themselves because of the Federal Statute referred to as ERISA[4]. Although the California decisions of Wickline and Wilson theoretically point out the potential for liability of third party payors, this federal statute has made it extremely difficult to successfully sue a managed care organization for utilization review decisions.

ERISA (Employment Retirement Income Security Act) was enacted in 1974 for the intended purpose of insuring that beneficiaries of employment benefit plans have a remedy in the event that they were inappropriately denied benefits contrary to the terms of the plan's policy. Although providing such a remedy, its effect has been to displace all other claims of any nature. ERISA explicitly establishes a broad preemption that precludes the beneficiaries of an employee benefit plan from bringing any claim or cause of action except as specifically provided in the federal statute. The specific language of ERISA states that it "shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan [covered by ERISA][5]. The term "state law" includes all laws, decisions, rules, regulations, or other state action having the effect of law, or any state. Consequently, this broad preemption applies not only to those state laws that expressly regulate benefit plans, but also to all legal actions when brought in connection

with, or arising out of, benefits received from a covered plan. This statute, enacted long before widespread institution of utilization review and cost-containment mechanisms in health insurance policies has created an impact that was likely unintended to Congress at the time the law was passed. Beneficiaries of health insurance plans are restricted to recovering against MCO's damages limited to the monetary amount of benefits denied and cannot recover any damages for the impact of those decisions.

In the 1985 case of Massachusetts Mutual Life Insurance v. Russell[6], a participant in health care benefits plan brought a claim against her employer, the plan administrator, for the refusal to pay health insurance benefits under its plan. The plaintiff claimed that the wrongful denial of benefits caused her psychological disability to worsen. The plan was a "covered plan" as defined by ERISA. The United States Supreme Court denied the participant from recovering any extra-contractual damages such as pain and suffering, consequential losses, and punitive damages because such damages were not provided for in the statute. Effectively, this decision limited the damages recoverable by a plan participant to the benefits, or the monetary cost of such benefits, that should have been provided under the plan. The Massachusetts Mutual decision established principles that were relied upon the the Fifth Circuit U.S. Court of Appeals when it ruled that ERISA preempted state law negligence claims against a managed care organization for utilization review and management decisions that contravened good medical practice. In the 1992 case, Corcoran v. United Healthcare[7], a physician had requested approval for inpatient hospital care of a high-risk pregnancy patient one month in advance of her expected delivery date. The utilization review company determined the hospital care was not medically necessary and therefore not covered under the health plan. The review did, however, approve ten (10) hours per day of home health care. Prior to the delivery date, the fetus became distressed and died. The employee/beneficiary instituted an action for compensatory and punitive damages based upon her claim that the insurer was negligent in denying medically necessary benefits. In its decision the Court said that the plaintiff's emotional distress as a consequence of negligent medical decisions by the HMO utilization mechanism, were preempted by ERISA. Once again, the Congressional enactment was interpreted to provide the beneficiary redress solely limited to the amount of the plan benefits that were denied.

However, the Appellate Court for the Fifth Circuit was troubled by the impact of ERISA. It recognized that by its decision the plaintiff was essentially left without a remedy for the substantial harm that arose out of the utilization review decision conducted by United Healthcare. In its decision, the Court stated that the unfortunate impact of ERISA may mean that "bad medical judgements will end up being cost-free to the plans that rely on [utilization review] to contain medical costs."[8] However, since courts are not allocated the task of enacting legislation, it felt constrained to reach a decision consistent with the law in its present form. It called upon Congress to reevaluate ERISA to determine whether it continues to serve the "noble purpose of safeguarding the interests of employees."[9]

"Because Courts are limited to their ability to carve out exceptions to ERISA, legislative bodies have started to initiate their own actions."

Given concerns similar to those raised by the Fifth Circuit Court in Corcoran, other courts and state legislatures have begun to address the safe harbor for MCO's created by ERISA by carving out exceptions to the preemption. In Dukes v. Healthcare, Inc.[10] the Third Circuit Court of Appeals determined that an HMO can be vicariously liable for the physician's decisions because the HMO was operating as a provider of health care. The plaintiff's claims fell outside the scope of ERISA since the beneficiary not only received payment for services but the actual medical care itself was provided through the HMO itself. Furthermore, recently the United States Supreme Court has allowed limited state legislative enactments that affect ERISA plans, although not in the area of utilization review decisions.

Despite this trend that MCO's may by liable for the quality of care provided and the negligence of its medical care providers, ERISA will still preempt lawsuits if the claim involves benefit plan administration. Because Courts are limited to their ability to carve out exceptions to ERISA, legislative bodies have started to initiate their own actions. In May, 1997, the Texas state legislature passed a law allow-

Continued on next page

ing health maintenance organizations and other managed care organizations to be held liable for negligent medical decisions when a treatment decision adversely affects patient's health. New Jersey has enacted similar legislation and other states appear to be following. However, it remains questionable whether any of this legislation will have the impact anticipated.

Congress has also been considering legislation to hold managed care plans for medically negligent actions arising from the plan's cost-containment mechanisms. Presently there has been no enactment that abrogates the effect of the ERISA preemptions.

For the few plans not covered by ERISA preemption, the 1993 Fox v. Health Net of California[11] case illustrates what juries can do in cases where health care plan is not exempted by ERISA. The plaintiff was a member of a public school district benefit plan and ERISA does not cover governmental benefit plans. The deceased plaintiff was a thirty eight year old schoolteacher with advanced breast cancer at the time she was denied coverage for an autologous bone marrow transplant. Health Net, a large California HMO, claimed that such treatment was not a "covered service" under the plan. Evidence was introduced at trial that financial incentives existed for executives successful at reducing overall plan costs. The jury returned a verdict for $89 million dollars.

Because the future of the ERISA preemption is questionable, and with jury awards such as Fox, some MCOs have sought to further limit their exposure by shifting liability for utilization review decisions to the physicians through indemnification clauses in the managed care contract. The effect of those clauses is to allocate potential liability from the MCO to the provider claiming that the physician, not the MCO, is engaged in medical decision making. MCO's claim that utilization review is solely a cost containment mechanism and does not interfere with the physician's independent medical judgement. Consequently, a loss suffered by the failure to treat arises out of the medical provider's negligence, for which the physician should be solely responsible. The physicians have attempted to refute this position by suggesting that the MCO's limitation on treatment options, restrictions on length of stay and choice of provider have by default asserted itself into the medical decision making process. In so doing, they should share in the responsibility when such medical decisions go awry.

While the debate is played out in Congress and among State legislatures, about legitimate cost-containment mechanisms and whether MCO's will be held responsible for substandard decisions made by utilization review, physicians must heed the warnings of Wickline. Although not an insurer of medical care, to reduce potential liability, physicians must exercise their responsibility as gatekeeper and not merely comply "without protest" with the limitations imposed by a third party payor when medical judgement dictates otherwise. ■

"Physicians must exercise their responsibility as gatekeeper and not merely comply "without protest" the limitations imposed by a third party payor when medical judgement dictates otherwise."

1. Wickline v. State of California,239 Cal. Rptr. 810 (Cal. Ct. App.1986)
2. Id. at 819
3. Wilson v. Blue Cross of So. Cal., 271 Cal. Rptr. 876 (Cal. Ct. App. 1990).
4. ERISA 514,29 U.S.C. 1144.
5. ERISA 514(b)(2)(A).
6. 437 U.S. 134.
7. 965 F.2d 1231 (5th Cir. 1992).
8. Id. at 1338.
9. Id. at 1338.
10. 57 F.3d. 350 (3rd Cir., 1995).
11. 219 C.A. Super Ct. 692 (1993).

Kevin Giordano is a partner with the firm of Keyes and Donnellan of Springfield. The firm is known to HDMS members as a worthy ally in medical malpractice defense, but is also a general practice firm emphasizing health care law, estate planning, and corporate and commercial litigation. Attorney Deborah Bloom, daughter of 50 year HDMS member Bernard Bloom, is managing partner.

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The Future of Health Care in America - a Business Perspective

Kenneth S. Abramowitz, a health care analyst with Sanford C. Bernstein Co., gave a grand rounds at Holyoke Hospital, September 19, 1997, replete with data regarding the current evolution of the U.S. health care system. His conclusions and recommendations to physicians are excerpted below.

Conclusions

Say NO to anachronistic price controls and excessive bureaucratic regulation, as well as excessive provider cuts and inadequate incentives to join Medicare and Medicaid HMOs.

Say YES to accepting more responsibility:

Taxpayers - accept employer tax cap and higher excise tax on cigarettes, liquor, cholesterol, and fat.

Corporations - accept employer tax cap, immediately buy at least a catastrophic plan for every employee; peg insurance contributions to the HMO rate, and pay at least 75% (preferably 100%) of the cost to join a good HMO for all employees, integrate group health and workers' compensation and charge employees for automobile health insurance component.

Consumers - choose between higher prices and unlimited access vs. lower prices and limited choice; do not ask for both through "any willing provider" laws.

AARP - become more responsible and consider society's financial capabilities; accept managed drug and long term benefits only for those who join HMOs.

Labor Unions - accept tax caps, not provider price controls.

Hospitals - form PHOs and accept capitation; merge together, close redundant capacity.

Physicians - form larger medical groups and accept capitation.

Insurance Carriers - Focus on broadening managed care offerings; lobby for modest employer mandate in conjunction with insurance reform; pay for experimental procedures for those in genuine clinical trials. Create standard claim form.

HMOs - accept the lower margins inherent in broadening exposure to Medicaid, Medicare, small group and individual markets; pay for experimental procedures for those in genuine clinical trials.

Pharmaceutical and Medical Device Companies - moderate price inflation, dramatically raise R&D spending, provide free drugs to the poor.

State Government - set up multiple competing health alliances through existing insurance brokers, with voluntary (and perhaps, in time, mandatory) enrollment for employers with fewer than 50 employees, individuals, and Medicaid. For those not providing health insurance, create employer/employee mandate to provide defined contribution of $500 per employee and then grow it over time.

Federal Government - stop looking for a quick fix; modify long-term incentives through employer tax caps and higher sin taxes; negotiate guaranteed access to a good HMO for all uninsured Americans long-term and catastrophic health insurance short-term; funnel all minimum wage increases into employer paid health insurance over the next ten years.

Republicans - Propose a genuine, realistic health plan alternative using some modest employer/employee mandate.

Democrats - Propose a responsible and honest alternative to the Clinton Plan. Stop confusing health reform with a large government role, and massive income redistribution. Stop looking at the government as a public automated teller machine.

President Clinton - Declare that PAC contributions are retroactively an illegal form of

bribery; arrest everyone in Congress; allow parole for those who support lightly managed competition; transport any supporters of "Medical Savings Accounts" back in time into the 1800's and opponents of a $500 annual defined contribution insurance mandate back into the Middle Ages; keep any supporters of global budgets or single payer systems in jail forever or deport them to Russia.

Implications for Physicians

- Join, form, or expand medical groups to reduce overhead and increase peer review.
- Increase primary care capability.
- Quantify certain quality measures and constantly strive to improve upon those targets.
- Continuously upgrade MIS and EDI; invest in creating automated medical records, where appropriate.
- Expand methodically on a geographic basis; acquire or merge with competitors when appropriate.
- Position yourself to accept capitation contracts; work more closely with the hospital so as to be able to jointly participate in capitation contracts.
- Work with a selective group of HMOs to offer low-cost insurance policies for small employers not presently offering health insurance.
- Consider selling the medical group to a professional manager like MedPartners or PhyCor.
- Keep learning, specializing, and intellectually progressing.
- Contingency plan for a further deterioration in the reimbursement environment.

Let's Emulate the Honey-Bee!

In ancient Greece, three Fates were said
To spin, to mete, to cut the thread
Of life that measured length of stay
Of all of those alive that day.

But length of stay - mere growing old -
Does not quite reach the standard, gold;
The number of one's years since birth
Does not proclaim a person's worth.

For years are given us on loan
To use as worker - - or as drone,
In life's bee-hive, to you and me;
Let's emulate the honey-bee!

And when the last Fate snips the skein,
Let's be assured no doubts remain
That we have lived a life well-spent
In 'honey-bee accomplishment'.

Accomplishment should be our quest,
And all of us should do our best,
So when the race of life's been run
It may be said by all: "Well done!"

S.F. Potsubay 97'

Dr. Samuel Potsubay is celebrating 50 years of membership in the HDMS. His efforts to elucidate the true meaning of "length of stay" are appreciated.

A Scholarship Informational

Bernard Bloom, M.D.

The Scholarship Committee of the Hampden District Medical Society recently met and awarded seven outright scholarships of $1,000.000 each and four Millman Foundation Scholarship Loans also in the amount of $1,000.00 for each student. Seven students are at the University of Massachusetts School of Medicine, three at Boston University School of Medicine and one at Tufts University School of Medicine. In past years, we have sent awards to students enrolled in medical schools in Albany, New York, Chicago, Illinois and Washington D.C.

This year we felt it would be of interest to our readers to have a brief background of the Scholarship Committee and how we work.

Each year, $10.00 of every Hampden District Medical Society member's dues go to our Scholarship Fund to award outright scholarships to medical students.

In 1977, following the death of our revered Dr. Max Millman, the Dr. Max and Ida L. Millman Scholarship Foundation was established by the Millman Family, many local friends and HDMS physicians. Dr. Millman was a past president and for many years the Editor-in-Chief of the Hampden Hippocrat. Supporters of this scholarship fund continue to send contributions throughout the years. One contributor has sent $1,000.00 annually since the establishment of the fund. In order to have this fund continue indefinitely, it was decided that it would be set up as a scholarship loan instead of an outright scholarship. Students are not required to begin re-payment until approximately six years after medical school graduation. This allows them to complete their residencies, internships and fellowships and to be ready to go into actual practice as a full-fledged working physician. The interest rate for re-payment is set at 0% and the student may re-pay in amounts that they are comfortable with. One student faithfully sent us $25.00 a month until his obligation was completed. Our students are very grateful for the financial help and they all have taken their responsibility of re-payment very seriously. Thus, the Millman Foundation flourishes.

The requirements for the HDMS scholarships and the Dr. Max & Ida L. Millman Foundation scholarship loans are the same. The student must be a resident of Hampden County, Massachusetts. They must be enrolled in an accredited medical school and must have good grades. There are separate applications for the HDMS Scholarships and the Millman Foundation Scholarship Loans that must be completed by each student applying. The forms for the 1998/1999 school year are available at the society's office now and they must be completed and returned by the student by September 1st of 1998.

The Scholarship Committee would remind our society members and friends that contributions are always needed. Please also feel free to send in contributions in celebration of events or for named memorials by friends and district members. Contributions should be sent to the Dr. Max & Ida L. Millman Foundation, c/o Hampden District Medical Society, Suite 22, 1111 Elm Street, West Springfield, MA 01089. An acknowledgement card from the Millman Foundation will be sent to the contributor and to the family of the person they wish to honor.

With the high cost of medical education rising rapidly, we appreciate all the financial help made available to the committee for awarding medical school scholarships. ■

Dr. Bloom is a 50 year HDMS member and current scholarship committee chair.

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- **Patient Protections** Above all, preserve the ability of physicians to act as advocates for their individual patients. Do not allow insurers to "gag" physicians or withhold medically necessary treatments from their patients.
- **Medicare Reform** Make the Medicare program solvent. Expand patient choice of plans. Allow future growth rates that cover patients needs. Retain special protection for the vulnerable and elderly.
- **Medical Education and Research** Continue to support medical education and research so we can find cures for killers such as AIDS and cancer.
- **Public Health Problems** Expand prevention and treatment programs to combat AIDS, drug abuse, smoking and violence. These problems cost billions of dollars and millions of lives.
- **Liability Reform** Enact meaningful liability reform to ensure fair compensation to patients with legitimate claims while eliminating excessive malpractice awards that lead to defensive medicine.

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In Memoriam

George B. Corcoran, M.D., Dr. George B. Corcoran Jr., 78 , died August 28, in Baystate Medical Center, Springfield. He retired as chief of surgery and chairman of ophthalmology at Mercy Hospital. He was also on staff at Wesson Memorial Hospital, Springfield, the former Providence Hospital, Holyoke, and Baystate Medical Center.

He was a consultant in ophthalmology at Wesson Municipal Hospital, Wing Memorial Hospital of Palmer, Noble Hospital of Westfield, and Ludlow Hospital.

He was also in a private practice partnership prior to retirement in 1987.

He was president of Springfield Eye Associates, and in 1972, helped invent the Frigitronics Fiberoptic Scleral Transilluminator Retinal Cryoprobe.

He was born in Springfield and graduated from West Springfield High School in 1937, American International College, Brown University in 1941, Yale University School of Medicine in 1944, where he later taught, and did postgraduate work at the University of Pennsylvania.

He was a member of local, state and national medical and ophthalmology associations. He was also a member of the Quarter Century Wireless Association, American Radio Relay Association (KICYD), Kiwanis, 100 Club and Knights of Columbus.

He leaves his wife, Sylvia Sargent Corcoran, formerly Eleanor M. Corcoran; two sons, Dr. George B. Corcoran III of Northville, MI, and Brian D. Corcoran of Houston, TX, five daughters, Diane Marion of Willimantic, CT, Carole Anne Corcoran of West Yarmouth, MA, Beth Corcoran Drolet of Ste. Foy, Quebec, Canada, Sandra Jean Havens of Sterling, CT, and Margaret Ann Crahan of South Yarmouth, MA; two stepsons, David Burdette of Willimantic, CT, and Duane Burdette of Virginia Beach, VA; two stepdaughters, Karen Zebrowski of Windsor, CT, and Stacey Fulton of Storrs, CT; 22 grandchildren and a great grandchild; a brother, Dr. Joseph Corcoran of Springfield; and two sisters, Cecilia Ann Kenny of Sedona, AZ, and Alice Marie Foley of Cleveland, OH. ■

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Short Notes

Hospice Life Care Offers Free Consumer Guide

HOLYOKE - A new consumer guide to hospice services in Massachusetts, entitled "Choosing Hospice," is available at no cost through Hospice Life Care. The 16-page booklet, produced by the Hospice Federation of Massachusetts with grant funding, answers many of the most commonly asked questions about health care options for patients and families who are facing a terminal illness.

"This guide enables people to learn about hospice as soon as they begin to have questions," says Pat Cavanaugh, director, Hospice Life Care. "Too often, the subject of hospice care doesn't come up until the patient's life expectancy is measured in weeks or even days. Unfortunately, many people don't even know that hospice can provide the greatest benefit to the patient and the family when we have the opportunity to serve them for several months. We're hopeful that this information will enable individuals to make informed decisions about the choices that are available to them."

"Choosing Hospice" was made possible through grants from the Robert Wood Johnson Foundation and the Friends of Hospice. A limited number of copies are available and will be distributed on a first come-first serve basis. For information on how you can receive a copy, please call Hospice Life Care at 413-533-3923 or write 330 Whitney Avenue, Suite 500, P.O. Box 10428, Holyoke, Ma 01041-2028. ■

Lymphodema Awareness

There is an opportunity for the readers of the Hampden Hippocrat to gain an understanding of a specialty treatment technique for post-mastectomy lymphodema reduction by speaking with a Dr. Vodder, Certified Manual Lymphatic & Combined Decongestive Therapist.

This technique involves the soft tissue mobilization in patients who are having to deal with the swelling, pain, skin changes and compression of nerves that is symptomatic of lymphodema.

Typically, women who have had a mastectomy, lumpectomy or radiation of any of their lymph nodes suffer from lymphodema. By mobilizing and stimulating the lymphatic system through a series of hands-on techniques and educating the patient on skin care and self-bandaging to prevent the re-fill of edema, patients often experience a significant reduction in edema and may be fitted for compressive garments to maintain size. This is not only beneficial to their overall health following procedures to fight breast cancer, but can help to re-build their body image and reincorporate their arm into their body scheme & function of the arm itself.

To find out more, feel free to contact me, Judy Duvall, at 413-284-5238, or Ruth Coopee, MOT, OTR/CHT - certified Dr. Vodder MLD & CDT Therapist on staff at Wing at 413-284-5254.

This special certification involves 160 hours of education on the lymphatic system, full body treatment techniques and bandaging, as well as the treatment of pathological conditions. ■

Letters to the Editor

Dear Dr. Flint,

I have received your message regarding staffing changes. We all realize, that Baystate Medical Center, like all U.S. hospitals, is a victim of outside forces and has to adapt to (mis-)managed care. I also realize, that it is politically unwise for hospital officials to "tell it like it is". However, it is disingenuous to assert, that "(n)one of these changes will diminish the quality of direct patient care." As a physician I realize that staff morale, at all levels, has become lower than it ever was during my active career (now 3 years in the past). As a patient, who at my age uses health services at an ever increasing rate, I find that care is not what it used to be.

Though it may be politically incorrect to do so, you would perform an invaluable service (at least for Western Massachusetts, but probably for a much larger area) if you were to publish the adverse forces, that affect medical care in this era of MBAs supplanting MDs as the chief movers in the health care arena. ■

Very Truly Yours
Walter F. Tauber, M.D.

Dear Member of the Medical Staff,

We are all too familiar with the dramatic effects which managed care and Medicaid-Medicare reductions are having on health care. There has been a devastating impact on hospitals across the country who have had to lay off hundreds of health care workers.

Many people have speculated about whether we would face a major layoff at Baystate Health System. Fortunately, rumors that massive layoffs are coming to Baystate Health System this year are not true; however, we are in the process of reducing managers and staff in some areas and scaling back programs at all our corporations to reach our budget goals for the coming year.

Many of the changes will be transparent to you, such as a reduction in supervisory and management positions, a consolidation of clerical staff in some areas, and partnering with other companies in some selected areas. All the changes will be communicated directly to affected groups.

Throughout this process we have had a singular focus on quality and safety. None of the changes will diminish the quality of direct patient care.

We are at a critical juncture in our history - we have been forced to reduce expenses at the very time we want to expand our Integrated Delivery System and improve care and services across the region through advanced technology and new models of care. We must conserve our resources and focus our energies on building a Health System for the future, while maintaining the highest quality of care today.

A great deal of our success is due to the dedication and hard work of our Medical Staff. We are in partnership with you - we do not intend to compromise our success or diminish our quality.

I thank you for your continued support as you adjust to these changes that are mandated by the external environment. ■

Loring S. Flint, Jr., M.D.
Senior Vice President Medical Affairs
Baystate Health Systems

In Memoriam

Henry Polchlopek, M.D., Dr. Henry W. Polchlopek, 73, of Chicopee died October 20, 1997 at Baystate Medical Center in Springfield. He practiced medicine here from 1957-1992.

He interned at Springfield Hospital, and served his residency at Boston City Hospital. He also taught at the Tufts University School of Medicine, and lectured at the Boston College School of Nursing.

While chief resident at Boston City Hospital, he researched in the circulation laboratory on artificial heart-lung machines, heart catheterization studies, and heart surgery.

He served the city's Polish community, and made house calls to the housebound elderly after retirement.

A lifelong resident, he was a communicant of the Basilica of St. Stanislaus, Bishop and Martyr.

He was a 1941 graduate of the High School, and attended the Western Massachusetts College of Pharmacy.

He was an Army Veteran of World War II, and served in Normandy, Ardennes, Rhineland, and Central Europe campaigns in 1944-1945. He was a combat medical corpsman and staff sergeant with the 552nd Field Artillery Battalion, and was awarded the Purple Heart and Bronze Star. He was discharged in 1945.

He was a cum-laude graduate of Tufts University in 1949, and received a degree in medicine from the Tufts University School of Medicine in 1953.

He was a member of the Andrew Balut Polish-American Veterans Post, the Kosciuszko Foundation, the Hampden District Medical Society, and the American Medical Association.

He was a past president of the American Heart Association and the Polish National Medical and Dental Association.

He served on the city's Board of Health, and belonged to the Chicopee Sportsmen's Club.

His wife, the former Wilhelmina A. Smolak, died in 1984.

He leaves two sons, Dr. Henry M. of Medford, and Dr. Stanley W. of Amherst, NH; a daughter Mary P. Dee of Longmeadow; three grandchildren, and a friend, Margaret R. Yopak of Granby. ■

Hospice Life Care

Hospice Life Care provides compassionate care to terminally ill patients and their families. Hospice's holistic approach to care seeks to make patients as comfortable as possible, and to manage symptoms so that their last days may be spent with dignity and quality. Services are provided primarily at home. A nursing home program is also available.

A program of Visiting Nurse Services of Western Massachusetts, Inc.

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Hospice Life Care's TRANSITIONS PROGRAM Seeks Volunteers for Errands and Transportation

HOLYOKE, MA - The Transitions Program of Hospice Life Care will be offering a six hour training for men and women who are interested in providing transportation and running some errands for pre-hospice patients. The day-time training will consist of information and an orientation to the Transitions program. Transitions is a new, free volunteer service offered by Hospice Life Care to persons who have limited life expectancy and who may still be receiving treatment for their illness. Volunteers transport patients to doctors' appointments and run an occasional errand during the day time hours in and around the Holyoke, Chicopee, West Springfield area and throughout the Pioneer Valley. People of all ages and backgrounds are encouraged to call for information and dates on the training. Call Jane at 533-3923, ext. 272. ■

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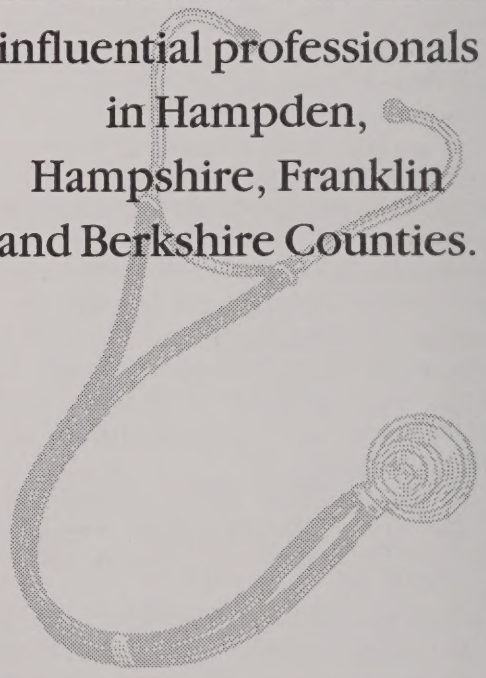

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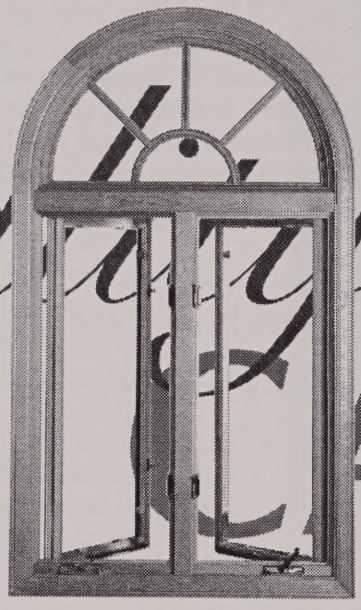

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